MANSOOR KARAMOOZ, M.D.
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URO-PLUS CENTER
MANSOOR KARAMOOZ, M.D.
16661 Ventura Blvd., #822
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PATIENT INFORMATION

Date: _____

Referring Dr. _____

Name: _____
(Last) (First)

Address: _____
Street City State Zip Code

Telephone: (____) _____ – _____

D.O.B. _____
Month Day Year

SS# _____

Marital Status: ☐M ☐D ☐W ☐S

Occupation: _____ Employer: _____

Work Address: _____ Tel.: (____) _____ – _____

Spouse: _____ Tel.: (____) _____ – _____

In case of emergency: _____
Name Relation Telephone

HEREBY IRREVOCABLY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MANSOOR KARAMOOZ, M.D. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE. COLLECTION FEES OR COURT COSTS NOT PAID BY THE INSURANCE CARRIER. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO OBTAIN THE MOST COMPLETE REIMBURSEMENT. A COPY OF THIS AUTHORIZATION AND RELEASE IS AS VALID AS THE ORIGINAL.

Patient Signature: _____ Date: _____

Insured Signature: _____ Date: _____